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ABSTRACT

An approach to the treatment of Hispanic (particularly Cuban) American families with drug abusing members is presented in this paper. The approach, developed by the Spanish Family Guidance Center in Miami, Florida, views dysfunctionality and drug abuse as emerging from a family's internal disorganization and ecological imbalance. In order to treat such a family, it is theorized, interactional patterns and structural relationships existing between its members, as well as other systems in the family's operational context, must be considered. The treatment plan described involves restructuring and reorganizing these interactions and relationships into patterns that will enhance the lives of the individual family members and of the family group as a whole.
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AN ECOSTRUCTURAL FAMILY THERAPY APPROACH TO THE
REHABILITATION OF THE LATINO DRUG ABUSER:
HISTORY AND DEVELOPMENT

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The Ecostructural Family Therapy model was adapted and developed by the Spanish Family Guidance Clinic of the University of Miami School of Medicine for the treatment and rehabilitation of the Latino drug abuser. The Spanish Family Guidance Clinic founded in 1972 has focused its efforts and resources in the design, development and implementation of culturally sensitive modalities of treatment congruent and consistent with the values, traditions and behaviors of the Spanish speaking population of Greater Miami.

The Latino population of this area consists of four hundred fifty thousand persons, ninety per cent of Cuban extraction, five per cent Puerto Ricans and five per cent other Latins. Thus when referring to the Spanish population of Greater Miami it can be assumed unless otherwise specified that it is, for the most part, a Cuban population of recent immigrant-hood having arrived in the United States during the last sixteen years.

Anthropological studies were conducted by our researchers in 1973 among the drug abusers in treatment at the various facilities in the Miami area. The large majority of the fifty subjects (Ss) interviewed were heroin addicts. Of these only two had grown up and developed their addiction in Miami. The rest had spent their formative years in some of the large Northeastern cities and come to Miami already addicted. This finding suggested that there were factors in Miami probably related to the organization and structure of the families of the newly arrived immigrants that were effectively preventing the onset of narcotic addiction among the Cuban families. The reason that the variables related to the paucity of narcotic addiction were hypothesized to be operative in the intrafamily

system was that hard drugs are as available in Miami as in other parts of the country, and heroin addiction as prevalent among the Black and Anglo population as elsewhere.

These same studies suggested that though the young person in treatment reported that the existing facilities were adequate for him, they also said that Anglo facilities were not meeting the needs of his family. The dissatisfaction of the family (with Anglo treatment facilities) as reported by the young abusers was hypothesized to be another factor influencing the low numbers of Latins in treatment, as well as their high drop-out rate.

The Spanish family is normally a close extended system whose members are highly interdependent on each other for the satisfaction of emotional needs as well as for providing solutions to problems in living. Thus without the support and cooperation of the Spanish family as it currently functions among those of Cuban extraction, it would be a difficult task to rehabilitate a drug abusing youngster.

These anthropological findings were substantiated by the clinical observations made during the same period by the counselors of the Spanish Family Guidance Clinic. When the clinics first went into operation early in 1973 it was soon found that though the drug abusing youth could be reached in their natural settings such as schools, parks, youth detention facilities and jails, they normally did not drop in, but were brought into treatment by a family member. The parents, aunts, uncles, grandparents, and even the Cuban school counselors almost always came to the clinic and in varying degrees had expectations to participate in the treatment as well as to be kept informed of the process.

In response to this need and in an effort to be culturally sensitive and relevant, a family therapy model began to be implemented. The theoretical framework chosen to develop the model was that of ecological family systems' theory (Auerswald, 1971). This model conceptualizes the family as a system in continuous interaction with other systems in its ecology. The locus of the conflict can be found in the dysfunctional transactions of the family with other societal systems, and/or in the transactions within the family. The family therapist then operates at the interface of the family and the significant systems with which it is interacting.

This particular theoretical framework seemed especially relevant to newly arrived immigrants, who did not have knowledge of the language nor the skills necessary to transact and interact effectively with the systems of the host culture.

The first task of the therapist, then, was to conduct a systems' analysis, enabling him to identify dysfunctional as well as functional interactions in order to change the former and strengthen the latter.

The therapist can intervene directly in the ecology of the patient (family) and/or work with the family mobilizing them and teaching them alternative ways of transacting that are more effective in their new milieu. Ecological family therapy is a problem oriented, active therapy that offers the creative therapist flexibility and alternatives in the process of patient rehabilitation.

Since one of the mandates of our federally funded clinics was to conduct a rigorous evaluation of our treatment models, we continued our search for family therapy procedures and techniques that could be easily yet systematically described, replicated and evaluated.

Our counselors, many of them paraprofessionals and new professionals, began to report that whenever they attended a family therapy workshop offered by a specialist in Structural Family Therapy (developed by Salvador Minuchin at the Philadelphia Child Guidance Clinic), they learned more and could implement faster what they learned. We then began to work with Dr. Minuchin, his researchers and clinicians in order to further develop our family therapy theory and techniques. Structural Family Therapy proved to be well accepted not only by the counselors but by the families. Thus our Ecological Family Therapy model became Eco-Structural Family Therapy.

Ecostructural Family Therapy seems to adapt very effectively to the expectations, values, traditions and behavior of our population.

Our population mobilizes for treatment usually in time of crisis. It is a crisis oriented population. Thus our patients come to us presenting concrete problems for which they want concrete specific solutions. Eco-Structural Family Therapy is present oriented and addresses itself immediately to the problems presented by the family.

The Cuban population also expects its therapists to be experts. They do not like to be asked how they can be helped. The expectation is that the "doctor" knows best, thus preferring a relationship of doctor-patient rather than peer-counselor (Sandoval, 1974). In Eco-Structural Family Therapy the therapist takes responsibility for the treatment and is in charge at all times. It can be seen that the value system of the therapeutic model is congruent with that of the population served.

Interestingly enough, these clinical findings and hypotheses have recently been supported by data yielded by a related but parallel study conducted by our basic research unit. A Cuban/American crosscultural comparison of values (Szapocznik, Kurtines, and Scopetta, 1976) utilizing as the conceptual framework, Kluckhohn and Stradtbeck's theory of value ori-

entation (1961) indicate that the Cubans have a preference for lineal relationships in the family system, are achievement oriented, value the present as opposed to the past or the future, and see themselves as subjugated to nature. When these values are taken into consideration in the design of a mental health delivery model the following can be concluded:

The culturally sensitive mental health provider must be prepared to take charge of the patient-therapist relationship, for the Cuban prefers to relate hierarchically. This is the mode of relationship of ecostructural family therapy.

Furthermore, since the Cuban feels powerless against the forces of his environment, he would look favorably upon a therapeutic model in which either his therapist intervened in his environment or at least taught him and mobilized him to do so. The ecological interventions built into the Eco-Structural model adequately meet this need. In addition, the present time orientation supports the finding in the clinics that the Cuban family comes for help in dealing with presently existing problems. Again, this is the same orientation of the Eco-Structural family therapist.

Thus our basic research findings substantiate the Eco-Structural Family Therapy approach designed from our experience in the clinics with our Miami Latino drug abusing patient.

Let us now describe in further detail this therapeutic model and its theoretical tenets.

An effectively functioning family is an open and flexible social system, maintaining profitable links with its ecology, and with a capacity for development and growth of itself, as well as each of its individual members. In contrast, a family becomes disrupted when it is

unable to cope with the demands of its ecological setting. At such times there may evolve a number of maladaptive coping patterns. For example, in the case of culture shock, the family system may develop such rigid boundaries that it does not permit effective interactions with the extrafamilial world. Or else, within the family, stiffling patterns of overprotectiveness and emmeshment may prevent the individual members from growing and actualizing themselves.

According to the conceptual framework of Ecological System Theory, the etiology of dysfunction is in the interaction between a dysfunctional client and other relevant systems impinging on it. Structural Family Theory views the individual's dysfunction as the result of a particular family system's way of organizing itself in attempts to deal with internal and external stresses. The integration of these two approaches yields a theoretical understanding and therapeutic flexibility which permit the therapist to effect reorganization and restructuring by working with and utilizing any part of the client's familial and extra-familial eco-system. The individual is seen as influencing his context and being influenced by it in constantly recurring sequences of interactions.

The major aim of Eco-Structural Family Therapy is to bring structural and ecological order into the disarray of a family within itself and within its community context. It is to help members of a family to become competent individuals in the family as well as in their extra-familial roles. The therapist, through the interactional

process of joining a family and its relevant ecological system, creates a new therapeutic system or experience wherein these reorganizational and restructuring interventions are made possible.

The focus of attention is the process of feedback between circumstances and the persons involved. A shift in the position of a person viz-a-viz his circumstances constitutes a shift of his experience. This in turn facilitates the use of new and alternative modalities of transactions within the family and with the extra familial milieu. It is a process that reinforces itself by permitting each individual in the system to experience new and more effective ways to deal with his/her environment.

The broadening focus implied by this approach affects every aspect of therapy. Starting with the diagnostic implications we see that a diagnosis is no longer a nonevolving label, fixed, static, "black and white", for example - drug user. Such a diagnosis implies only that the patient should stop using drugs and gives no clues as to how this is to be achieved. But on the other hand, the observation that the individual using drugs is responding to unresolved conflicts between the spouses, or to the family's intergenerational cultural gaps, or to conflicts between family values and peer group values all these provide a wide field of promising therapeutic interventions which in turn will yield a new non-stressful experience wherein the individual will no longer need to resort to the "patient-hood" of drug usage. The therapist can then work with individuals as subsystem, with the dyadic family subsystems, at the interface of the family system and societal systems, etc. but all of this therapeutic activity will be guided by a dynamic relational conceptual-

ization of the phenomena being treated.

Let us turn to an overview of the typical Latino families being studied by the Spanish Family Guidance Clinic. From the onset, these families present a very different picture from the typical Anglo drug clinic patient. We have found that the Latino family will rarely present drug usage as the problem for which therapy is sought. It is important to understand that the Latino views drug use/misuse or abuse as either socially condoned and not problematic (as in the case of mothers abusing sedatives and tranquilizers) or else as such a cultural taboo that disclosure becomes extremely difficult (as in the case of illegal drug use by adolescents).

With this in mind we have found that our Latin families most frequently request help because they perceive an adolescent to be "out-of-control, disobedient, in trouble with school or legal authorities." The parents see themselves as incapable of handling their children and come with the expectation that the therapist will literally take over the parenting functions. The first intervention to redefine the problem is made when, at Intake, the therapist insists that the whole family should come, thus engaging the parents in the problem-solving process.

The typical structure of the family system at Intake discloses very rigid and thus dysfunctional patterns of trying to cope with the stresses. The family is emmeshed and thus not able to tolerate differentiation among its members. The executive power is weakened (sometimes non-existent) in the parental subsystem and dysfunctionally placed in either an adolescent or a grandparent who is usually closely allied with the "identified-patient." To cope with its

ecological context, the family has built rigid boundaries around itself and has difficulty interacting with the extra-familial world in an enhancing manner. The marital couple has limited its communication to only those matters relating to the "patient-hood" of the identified symptom-carrier. The family is unable to arrive at conflict-resolution in even simple matters. All of these patterns repeat themselves over and over again in the same manner, regardless of the particular situation in which the family finds itself at any one time.

The problems being encountered by the family relative to acculturation are two-fold: On the intrafamilial dimension we find that parents are perceiving their alienation from their more acculturated children. To deal with this they either precipitate their own process of acculturation in a manner that is dysfunctional to themselves, or more commonly, they try to stifle the process in their children.

In this struggle, the executive functions of the parents become invalidated and the natural process of independence of the adolescents is fought against. The youngster is placed at the interface of the dysfunction so as to maintain the homeostasis of the system. That is, his/her dysfunction permits the system to stay together and gives the parents some "reason to control" while he/she is given an "excuse" to remain dependent.

On the extra-familial dimension, the system, perceiving the outside world as stressful and pressing for acculturation, begins defining rigid boundaries around itself which blocks healthy and necessary interactions with its life-context. The family then scapegoats the school system, or the peer system, or the occupational system, etc.

A commonly heard cry is "we never should have left our country."

Some have recently arrived, others have seen their children grow up in the U.S. - either way, they share in common a separation from mainstream American culture. A feeling of isolation that is held ambivalently between choice and consequence - between will to adhere to their own culture and need to adjust to the new. What settles in is confusion, an impasse that leads to disruption of intrafamilial structure evidenced by their inability to cope as a system with the natural developmental process of a family.

The adolescents may be signaled as the problem, but the spousal subsystem is indeed in trouble, the grandparents' roles are confused. The whole family is clumsy in its dealings with the extra-familial world and thus each of its members are in pain and stymied. The adolescents resort to illegal polydrug use, the adults will indiscriminately self-prescribe and abuse tranquilizers, anti-depressants and sedatives.

The therapeutic interventions are aimed at

1. bridging the cultural gaps within the family and between the family and its host ecology
2. facilitating new and more functional interactional patterns
3. promoting openness and flexibility within the family system and between the family and its ecology
4. assisting the family in developing a functional balance between individuation of its members and their inter-relatedness.
5. developing ecological interactions which are conducive to the enhancement of the life of the family and that of its members.

To do this the therapist utilizes the techniques and approaches of Structural Family Therapy at two levels: in working with the family system as well as in working with the family and representatives of their ecology. Furthermore, the therapist uses him/herself as a cultural bridge whenever culture conflict becomes evident as one of the precipitators of the dysfunctional transaction.

Summary

This paper presents an Eco-Structural Family approach to the treatment of Latino drug-involved families as adapted and developed by the Spanish Family Guidance Clinic. Based on this approach, dysfunctionality and drug use is seen as emerging from a family's internal disorganization and ecological imbalance. Consideration is then given to the interactional patterns and structural relationships existing between family members as well as family and other systems in their operational or life-context. A treatment plan thus evolves, aimed at restructuring and reorganizing these interactions and relationships into patterns which, according to the theory, are more conducive to the enhancement of the family's life as well as that of its individual members.

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